DWC-AD 10133.5455 Request for Dispute Resolution Before the Administrative Director (For injuries occurring on or after 1/1/04)OriginalResponse		Has employer accepted this claim?  ——Yes —— No  Has liability for injury been found by the WCAE  ——Yes —— No  Has it been more than 60 days since TTD ende  ——Yes —— No  Has PPD award been stipulated, issued/approve  ——Yes —— No		No found by the WCAB?     No ays since TTD ended?     No ated, issued/approved?	DWC Use Only		
Social Security Number	<b>,</b>	WCAB Number		,	DWC Unit Number		
Employee Name (Last) (First)					(MI) Phone	Date of Birth	
Address (Street) (City)					(State)	(Zip)	
Employer Name Phone				Insurance Company Name; Or, if Self-Insured, Certificate Name			
Address					Adjusting Agency Name (if adjusted)		
City, State, Zip					Claims Mailing Address		
Date of Injury Claim Number					City, State, Zip Phone No.		
Employee Representative (if any)					Employer Representative		
Firm Name					Firm Name		
Address					Address		
City, State, Zip Phone No.					City, State, Zip	Phone No.	
Vocational & Return to Work Counselor ( <u>if applicable</u> )  Firm Name  Representative Name							
Address (Street, City, State, Zip						Phone No.	
The Administrative Director is requested t documents)	o resolve the fo	ollowi	ng dispute becaus	se the	parties disagree on : (Please	describe <u>and attach all pertinent</u>	
				<u>Proof of Service: I declare under penalty of perjury under the laws of the State of California that on the date written below, I mailed a copy Copies of this request with a copy of any copies of pertinent-documents included with this request have been served on: to the following parties at the following</u>			
N. CD.	_			Admii P.O. E	30x 420603, San Francisco, C		
Name of Requester	D	Date		Signa	ture	<u>Date</u>	